SERFF Tracking Number:	*JEPL-125673253*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	*39195*
Company Tracking Number:	*LFF06321 ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application Part I LFF06321 et al*		
Project Name/Number:	*/LFF06321 et al*		

Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: Application Part I LFF06321 et al	SERFF Tr Num: JEPL-125673253	State: ArkansasLH
TOI: L08 Life - Other	SERFF Status: Closed	State Tr Num: 39195
Sub-TOI: L08.000 Life - Other	Co Tr Num: LFF06321 ET AL	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Authors: Ray Fortier, James Kane, Jeanine Taylor	Disposition Date: 06/06/2008
	Date Submitted: 06/03/2008	Disposition Status: Approved
Implementation Date Requested: 08/15/2008		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number: LFF06321 et al	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 06/06/2008	
State Status Changed: 06/06/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Hon. Julie Benafield Bowman

Commissioner of Insurance

Compliance-Life & Health

Attn: Joe Musgrove

1200 West Third Street

Little Rock, AR 72201-1904

SERFF Tracking Number:	*JEPL-125673253*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	*39195*
Company Tracking Number:	*LFF06321 ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application Part I LFF06321 et al*		
Project Name/Number:	*/LFF06321 et al*		

Re: Individual Life Application Forms
LFF06321 Application for Life Insurance (Part I)
LFF06322 Medical Supplement (Part II)
LFF06319 Premium Financing Supplement
The Lincoln National Life Insurance Company
Group & NAIC #: 020-65676

Dear Mr. Musgrove:

We are submitting the required number of copies of the above-referenced forms for your review and approval. The application and supplements are new forms and are not intended to replace any previously approved forms.

Upon approval, the Application for Life Insurance (Part I) and supplements will be used in applying for our individual life insurance products sold by properly licensed agents/representatives. The two supplements noted above along with previously approved application supplements will be used in conjunction with the Application for Life Insurance (Part I) when additional information is required, as applicable, and will constitute a part of the application for life insurance.

The forms received the following Flesch scores: Application for Life Insurance (Part I) 50.46, Medical Supplement (Part II) 52.54, and Premium Financing Supplement 51.57. These forms have been submitted concurrently to our Home State of Indiana and are pending approval. If applicable, the appropriate certifications, transmittals, checklists and filing fees are included. To the best of our knowledge and belief, these forms comply with all the applicable laws and regulations of your state.

We have bracketed several items within the forms as variable information to allow for flexibility in the content of the form. These items include: the Service Office address, listing of benefits and riders on the application, and form page number references. It is our understanding that changes to the bracketed items for new issues will not require a new filing of these forms. We confirm that the brackets will not actually appear on the forms at issue. Upon approval, we reserve the right to change the format of a form without altering the approved language, though it is possible page numbers may change.

We trust the information provided will be satisfactory and we look forward to your response. Should you require any

additional information, please feel free to contact me toll-free at 1-800-258-3648, extension 5426, or via the fax number or e-mail address shown below.

Sincerely,

James P. Kane
Analyst, Life Product Compliance
E-mail: James.Kane@LFG.com
Fax: 1-603-226-5128

Company and Contact

Filing Contact Information

James Kane, Compliance Analyst	james.kane@lfg.com
One Granite Place	(800) 258-3648 [Phone]
Concord, NH 03302-0515	(603) 226-5128[FAX]

Filing Company Information

The Lincoln National Life Insurance Company	CoCode: 65676	State of Domicile: Indiana
350 Church Street	Group Code: 20	Company Type: Life Insurance
Hartford, CT 06103	Group Name:	State ID Number:
(800) 258-3648 ext. [Phone]	FEIN Number: 35-0472300	

Filing Fees

Fee Required?	Yes
Fee Amount:	$60.00
Retaliatory?	No
Fee Explanation:	3 forms filed x $20.00 filing fee per form = $60.00.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Lincoln National Life Insurance Company	$60.00	06/03/2008	20637501

SERFF Tracking Number:	*JEPL-125673253*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	*39195*
Company Tracking Number:	*LFF06321 ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application Part I LFF06321 et al*		
Project Name/Number:	*/LFF06321 et al*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	06/06/2008	06/06/2008

SERFF Tracking Number:	*JEPL-125673253*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	*39195*
Company Tracking Number:	*LFF06321 ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application Part I LFF06321 et al*		
Project Name/Number:	*/LFF06321 et al*		

Disposition

Disposition Date: 06/06/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*JEPL-125673253*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	*39195*
Company Tracking Number:	*LFF06321 ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application Part I LFF06321 et al*		
Project Name/Number:	*/LFF06321 et al*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		No
Supporting Document	Application		No
Supporting Document	Readability Certification		Yes
Form	Application for Life Insurance - Part I		Yes
Form	Medical Supplement (Part II)		Yes
Form	Premium Financing Supplement		Yes

SERFF Tracking Number:	*JEPL-125673253*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	*39195*
Company Tracking Number:	*LFF06321 ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application Part I LFF06321 et al*		
Project Name/Number:	*/LFF06321 et al*		

Form Schedule

Lead Form Number: LFF06321

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LFF06321	Application/ Enrollment Form	Application for Life Insurance - Part I	Initial		50	LFF06321 Base Application Part I GENERIC Bracketed.pdf
	LFF06322	Application/ Enrollment Form	Medical Supplement (Part II)	Initial		53	LFF06322 Medical Supplement Part II GENERIC Bracketed.pdf
	LFF06319	Application/ Enrollment Form	Premium Financing Supplement	Initial		52	LFF06319 Premium Financing Supplement GENERIC Bracketed.pdf

Lincoln Financial Group®

The Lincoln National Life Insurance Company
Service Office: [PO Box 21008, Greensboro, NC 27420-1008]
(hereinafter referred to as "the Company")

IMPORTANT NOTICE
Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of these notices to each Proposed Insured.)

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

INVESTIGATIVE CONSUMER REPORT

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: Box 105 Essex Station, Boston, MA 02112. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)

Lincoln Financial Group®

The Lincoln National Life Insurance Company
Service Office: [PO Box 21008, Greensboro, NC 27420-1008]
(hereinafter referred to as "the Company")

IMPORTANT NOTICE
Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of these notices to each Proposed Insured.)

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

INVESTIGATIVE CONSUMER REPORT

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: Box 105 Essex Station, Boston, MA 02112. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)

Lincoln Financial Group®

The Lincoln National Life Insurance Company
Service Office: [PO Box 21008, Greensboro, NC 27420-1008]
(hereinafter referred to as "the Company")

APPLICATION FOR LIFE INSURANCE - PART I

APPLICANT INFORMATION - PROPOSED INSURED A (Required Section)

1. Proposed Insured A *(First, Middle, Last)*		2. ☐ Male ☐ Female
3. Date of Birth (If over age [70], please complete Section D.) *(mm/dd/yy)*	4. Soc. Sec. No.	5. Are you a citizen of the United States? ☐ Y ☐ N If "No," what country?
6. Place of Birth *(State, Country)*	7. Driver's License # & State	
8. Home Address *(Street, City, State, ZIP)*		
9. Occupation/Duties	10. Employer	
11. Business Address *(Street, City, State, ZIP)*		
12. Annual Earned Income $	13. Annual Unearned Income $	14. Net Worth $
15. In the last 5 years have you filed for bankruptcy? ☐ Y ☐ N *(If "Yes," please complete the Financial Supplement.)*	16. Primary Phone # ☐ AM ☐ PM	17. Work Phone # ☐ AM ☐ PM

COVERAGE INFORMATION *(As available per product)*

18. Plan of Insurance _____ 19. Amount of Insurance $ _____ *(Specified Amount, if UL or VUL)*

20. (i) Death Benefit Option *(Complete for Universal Life and Variable Universal Life Product only - not required for Term or Whole Life.)*
☐ Level ☐ Increase by Cash Value ☐ Increase by Premium ☐ Increase by Premium Less Policy Factor

(ii) Death Benefit Qualification Test (DBQT) - For IRS purposes, premiums will be tested using the Guideline Premium Test unless ☐ Cash Value Accumulation Test is checked (not available on all products or with all riders).
The DBQT cannot be changed after issue unless the terms of the policy require a change.

21. Save Age? ☐ Y ☐ N *(If not saving age, policy will be current dated.)*

22. Additional Benefits and Riders: *(If applicable)*

☐ [Supplemental Coverage $ _____
☐ Term on Spouse/Other Insured Rider $ _____ *(Please complete Section B - Applicant Information - Proposed Insured B)*
☐ Accelerated Benefit Rider
☐ Waiver of Premium
☐ Waiver of Monthly Deductions
☐ Waiver of Specified Premium $ _____
☐ Children's Term Insurance Rider] *(Complete Child's Supplement)*

☐ Other Benefits and Riders *(not listed above)*. (Please provide full details: e.g. coverage amounts/percentages/etc.):

BILLING INSTRUCTIONS *(As available per product)*

23. Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (EFT) ☐ Other _____

24. Modal Planned Premium: $ _____ 25. Lump Sum: $ _____ ☐ 1035 Exchange

26. Special Billing: *(check one, if applicable)* ☐ New List Bill ☐ Existing List Bill Number: _____

27. Source of Premium: _____ *(inheritance, loan, business activity)* 28. Automatic Premium Loan: ☐ Y ☐ N *(Complete for Whole Life only.)*

29. Premium Notices To: *(check one only.)* *(Please note we cannot bill to your agent.)*
☐ Owner in Question 31 ☐ Owner in Question 37 ☐ Insured at Business ☐ Insured at Residence ☐ Other *(indicate below)*

30. Special Instructions:

OWNER INFORMATION *(If left blank, Proposed Insured(s) will be owner)*

31. Owner Name	
32. Owner Address	
33. Relationship to Proposed Insured(s)	34. Owner Soc. Sec. No. / TIN
35. Date of Birth/Trust Date	36. Citizen of (Country)
37. Owner Name	
38. Owner Address	
39. Relationship to Proposed Insured(s)	40. Owner Soc. Sec. No. / TIN
41. Date of Birth/Trust Date	42. Citizen of (Country)

43. Is this policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? ☐ Y ☐ N

BENEFICIARY DESIGNATION (*Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.)*

Select Primary (P) or Contingent (C) Beneficiary for each line completed. If Trust, check here ☐.

44. ☐ P ☐ C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN c. Relationship to Proposed Insured
45. ☐ P ☐ C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN c. Relationship to Proposed Insured
46. ☐ P ☐ C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN c. Relationship to Proposed Insured
47. ☐ P ☐ C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN c. Relationship to Proposed Insured
48.	Special Instructions	

APPLICANT INFORMATION - PROPOSED INSURED A

49. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? ☐ Y ☐ N
(If "Yes", please complete and sign all required replacement forms.)

50. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*
If none, check this box: ☐
Please indicate the Type of coverage: Business (**B**); Key Person (**K**); or Personal (**P**).

Company	Face Amount	Policy Number	Issue Date *(mm/dd/yy)*	Replacement or Change of Policy?	1035 Exchange	Type
	$			☐ Y ☐ N	☐ Y ☐ N	
	$			☐ Y ☐ N	☐ Y ☐ N	
	$			☐ Y ☐ N	☐ Y ☐ N	
	$			☐ Y ☐ N	☐ Y ☐ N	

51. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? *(If "Yes," please provide details in the space provided.)* ☐Y ☐N

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	$		
	$		

52. What is the total amount of new life insurance coverage that will be placed inforce with all companies including this application? $_____

53. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? *(If "Yes", please complete the Premium Financing Supplement.)* ☐Y ☐N

54. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide further information in the "Details" space provided.)* ☐Y ☐N

GENERAL RISK INFORMATION - PROPOSED INSURED A

55. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? *(If "Yes", an Aviation Supplement is required; this includes balloon pilots.)* ☐Y ☐N

56. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? *(If "Yes", an Avocation Supplement is required.)* ☐Y ☐N

57. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? *(If "Yes", a Foreign Travel or Residence Supplement is required.)* ☐Y ☐N

58. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? *(If "Yes," please indicate what type and dates in the "Details" space provided.)* ☐Y ☐N

59. Have you ever been convicted of or are you awaiting trial for a felony? *(If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in the "Details" space provided.)* ☐Y ☐N

60. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the "Details" space provided.)* ☐Y ☐N

61. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)* ☐Y ☐N

Type:	Date First Used: *(month/year)*	Date Last Used: *(month/year)*	Amount and Frequency:

MEDICAL INFORMATION - PROPOSED INSURED A *(Answer this section only when required.)*

62. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

a. Date and reason of last visit:

b. Tests performed & treatment received:

63. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? ☐Y ☐N
Weight _____ lbs. b. If "Yes," by how many pounds? _____ ☐ Gain ☐ Loss

64.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? *(include age of onset)*	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

65. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*

Lincoln Financial Group®

The Lincoln National Life Insurance Company
Service Office: [PO Box 21008, Greensboro, NC 27420-1008]
(hereinafter referred to as "the Company")

SECTION A - HEALTH SUMMARY

APPLICANT INFORMATION - PROPOSED INSURED A

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

1. Proposed Insured A *(First, Middle, Last)*	2. Date of Birth *(mm/dd/yy)*

► **If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.**

	Yes	No
3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	☐	☐
4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	☐	☐
5. **Have you ever had any indication of, or been treated by a licensed medical professional for:**		
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	☐	☐
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	☐	☐
c. Anemia, leukemia, clotting disorder or any other blood disorder?	☐	☐
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	☐	☐
e. Asthma, emphysema, shortness of breath, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	☐	☐
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	☐	☐
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	☐	☐
i. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	☐	☐
k. Any disorder of the eyes, ears, nose or throat?	☐	☐
l. Any mental or physical disorder medically or surgically treated condition not listed above?	☐	☐
6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	☐	☐
7. Do you use alcoholic beverages? *(If "Yes", provide Type, Frequency & Amount.)*	☐	☐
Type _____ Frequency_____ Amount _____		
8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	☐	☐
9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐

10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.

11. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*

Lincoln Financial Group®

The Lincoln National Life Insurance Company
Service Office: [PO Box 21008, Greensboro, NC 27420-1008]
(hereinafter referred to as "the Company")

SECTION B - ADDITIONAL INSURED

APPLICANT INFORMATION - PROPOSED INSURED B

1. Proposed Insured B *(First, Middle, Last)*		2. ☐ Male ☐ Female
3. Date of Birth (If over age [70] please complete Section D.) *(mm/dd/yy)*	4. Soc. Sec. No.	5. Are you a citizen of the United States? ☐ Y ☐ N If "No," what country?
6. Place of Birth *(State, Country)*	7. Driver's License # & State	
8. Home Address *(Street, City, State, ZIP)*		
9. Occupation/Duties	10. Employer	
11. Business Address *(Street, City, State, ZIP)*		
12. Annual Earned Income $	13. Annual Unearned Income $	14. Net Worth $
15. In the last 5 years have you filed for bankruptcy? ☐ Y ☐ N *(If "Yes," please complete the Financial Supplement.)*	16. Primary Phone # ☐ AM ☐ PM	17. Work Phone # ☐ AM ☐ PM

18. Beneficiary for applicable Rider: a. Name	
b. Soc Sec. No./TIN	c. Relationship to Proposed Insured B

19. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? ☐ Y ☐ N
(If "Yes", please complete and sign all required replacement forms.)

20. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*
If none, check this box: ☐
Please indicate the Type of coverage: Business (**B**); Key Person (**K**); or Personal (**P**).

Company	Face Amount	Policy Number	Issue Date *(mm/dd/yy)*	Replacement or Change of Policy?	1035 Exchange	Type
	$			☐ Y ☐ N	☐ Y ☐ N	
	$			☐ Y ☐ N	☐ Y ☐ N	
	$			☐ Y ☐ N	☐ Y ☐ N	
	$			☐ Y ☐ N	☐ Y ☐ N	

21. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? *(If "Yes," please provide details in the space provided.)* ☐ Y ☐ N

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	$		
	$		

22. What is the total amount of new life insurance coverage that will be placed inforce with all companies including this application? $_____

23. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? *(If "Yes", please complete the Premium Financing Supplement.)* ☐ Y ☐ N

24. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide further information in the "Details" space provided.)* ☐ Y ☐ N

GENERAL RISK INFORMATION - PROPOSED INSURED B

25. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? *(If "Yes", an Aviation Supplement is required; this includes balloon pilots.)* ☐ Y ☐ N

26. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? *(If "Yes", an Avocation Supplement is required.)* ☐ Y ☐ N

27. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? *(If "Yes", a Foreign Travel or Residence Supplement is required.)* ☐ Y ☐ N

28. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? *(If "Yes," please indicate what type and dates in space provided below.)* ☐ Y ☐ N

29. Have you ever been convicted of or are you awaiting trial for a felony? *(If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in space provided below.)* ☐ Y ☐ N

30. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; on the space provided below.)* ☐ Y ☐ N

31. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)* ☐ Y ☐ N

Type	Date First Used: *(month/year)*	Date Last Used: *(month/year)*	Amount and Frequency:

MEDICAL INFORMATION - PROPOSED INSURED B *(Answer this section only when required.)*

32. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

a. Date and reason of last visit:

b. Tests performed & treatment received:

33. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? ☐ Y ☐ N

Weight _____ lbs. b. If "Yes," by how many pounds? _____ ☐ Gain ☐ Loss

34.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? *(include age of onset)*	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

35. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*

Lincoln Financial Group®

The Lincoln National Life Insurance Company
Service Office: [PO Box 21008, Greensboro, NC 27420-1008]
(hereinafter referred to as "the Company")

SECTION C - HEALTH SUMMARY

APPLICANT INFORMATION PROPOSED INSURED B

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

Proposed Insured B 1. *(First, Middle, Last):*	Date of Birth 2. *(mm/dd/yy)*:

► **If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.**

	Yes	No
3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	☐	☐
4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	☐	☐
5. **Have you ever had any indication of, or been treated by a licensed medical professional for:**		
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	☐	☐
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	☐	☐
c. Anemia, leukemia, clotting disorder or any other blood disorder?	☐	☐
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	☐	☐
e. Asthma, emphysema, shortness of breath, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	☐	☐
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	☐	☐
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	☐	☐
i. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	☐	☐
k. Any disorder of the eyes, ears, nose or throat?	☐	☐
l. Any mental or physical disorder medically or surgically treated condition not listed above?	☐	☐
6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	☐	☐
7. Do you use alcoholic beverages? *(If "Yes", provide Type, Frequency & Amount.)* Type _____ Frequency_____ Amount _____	☐	☐
8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	☐	☐
9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐

10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.

11. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*

Lincoln Financial Group®

The Lincoln National Life Insurance Company
Service Office: [PO Box 21008, Greensboro, NC 27420-1008]
(hereinafter referred to as "the Company")

SECTION D - DEFINED AGE QUESTIONNAIRE
(Complete if either Proposed Insured is age [70] or over.)

1. Proposed Insured A *(First, Middle, Last)* _____

2. Proposed Insured B *(First, Middle, Last)* _____

	Proposed Insured A	Proposed Insured B
3. Will you, the proposed insured and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	☐Y ☐N	☐Y ☐N
4. Have you, the proposed insured, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf which will have an ownership or beneficial interest in this policy?	☐Y ☐N	☐Y ☐N
5. Have you, the proposed insured, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the proposed insured, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	☐Y ☐N	☐Y ☐N
6. Have you, the proposed insured, ever sold a policy to a life settlement, viatical or other secondary market provider, or are you in the process of selling a policy?	☐Y ☐N	☐Y ☐N
7. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*		

OWNER INFORMATION

8. Owner Name _____	Owner
9. Will you, the proposed owner and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	☐Y ☐N
10. Have you, the proposed owner, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf?	☐Y ☐N
11. Have you, the owner, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the owner, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	☐Y ☐N
12. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? *(If "Yes", please complete the Premium Financing Application Supplement.)*	☐Y ☐N
13. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*	

SERVICE OFFICE ENDORSEMENTS *(For Company Use Only. We will attach additional documentation as needed.)*

SUITABILITY

Complete only if applying for Variable Life Insurance and submit allocation form(s) with this Application:

1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	☐ Y ☐ N
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	☐ Y ☐ N
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	☐ Y ☐ N
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	☐ Y ☐ N

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, declare that my tax identification or social security number as shown is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of: a) Part I (including Sections A-D if needed); b) Part II Medical Application, if required; c) any amendments to the application(s) attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. This Application for Life Insurance - Part I shall be complete when it includes Application Information - Proposed Insured A, and any or none of the following (please check, as applicable, included Sections A-D):
   ☐ Section A- Health Summary -Proposed Insured A, ☐ Section B- Applicant Information -Proposed Insured B,
   ☐ Section C -Health Summary -Proposed Insured B, and ☐ Section D - Defined Age Questionnaire.
2. I/We further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me/us; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured(s); and 3) the Proposed Insured(s) remain in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.

   I/We have paid $ _____ to the Agent/Representative **in exchange for the Temporary Life Insurance Agreement**, and I/we acknowledge that I/we fully understand and accept its terms. *(Please complete Temporary Life Insurance Agreement and submit with application.)*
3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true.
5. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
6. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURES

All jurisdictions except AR, AZ, CT, DC, FL, KS, KY, LA, ME, MN, NJ, NM, OH, OK, PA, TX, VA and WA. Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

AR, DC, KY, ME, NM, OH and PA Only. Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

TRUST VERIFICATION

I/WE hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

AUTHORIZATION

Each of the undersigned declares that:

I/We authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me/us or my/our physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I/We authorize the Company to disclose information related to my insurability to MIB, Inc., and to other insurers to whom I/we may apply for coverage.

I/We acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

☐ I elect to be interviewed if an Investigative Consumer Report is prepared.

SIGNATORY SECTION

Signed in _____, this _____ day of _____ _____
(state) (month) (year)

Signature of Proposed Insured A
(Parent or Guardian if under 14 years of age)

Signature of Proposed Insured B (If coverage applied for)
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

TO BE COMPLETED BY AGENT ONLY

(i) Does the applicant have any existing life insurance policies or annuities? ☐ Y ☐ N

(ii) Do you know or have you any reason to believe that replacement of insurance is involved? ☐ Y ☐ N
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative
(Please Print)

APPLICABLE TO VARIABLE LIFE ONLY

I have reviewed the Application, Supplements, New Account Form and allocation forms and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

Name of Registered Principal of Broker/Dealer (Please Print)

Lincoln Financial Group®

The Lincoln National Life Insurance Company
Service Office: [PO Box 21008, Greensboro, NC 27420-1008]
(hereinafter referred to as "the Company")

MEDICAL SUPPLEMENT
(Part II of Application)

Proposed Insured_____ Date of Birth *(mm/dd/yy)* _____

1. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

Name	Address	Phone

a) Date and reason of last visit: _____

b) Tests performed & treatment received: _____

► **If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.**

		Yes	No
2.	Height _____ ft./_____ in. Weight _____ lbs. a) Has your weight changed by more than 10 pounds during the past 12 months? b) If "Yes", by how many pounds? _____ Gain _____ Loss	☐	☐
3.	Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	☐	☐
4.	Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	☐	☐
5.	**Have you ever had any indication of, or been treated by a licensed medical professional for:**		
	a) Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	☐	☐
	b) Any tumor, cancer, cysts, melanoma, lymphoma, or any disorder of the lymph nodes?	☐	☐
	c) Anemia, leukemia, clotting disorder or any other blood disorder?	☐	☐
	d) Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	☐	☐
	e) Asthma, emphysema, shortness of breath, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	☐	☐
	f) Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	☐	☐
	g) Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
	h) Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	☐	☐
	i) Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
	j) Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	☐	☐
	k) Any disorder of the eyes, ears, nose or throat?	☐	☐
	l) Any mental or physical disorder or medically or surgically treated condition not listed above?	☐	☐
6.	Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	☐	☐
7.	Do you use alcoholic beverages? *(If "Yes" provide type, frequency & amount.)* Type _____ Frequency _____ Amount _____	☐	☐
8.	Have you ever been treated for drug or alcohol abuse or been advised by licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	☐	☐
9.	In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐

10. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)* ☐Y ☐N

Type	Date First Used: *(month/year)*	Date Last Used: *(month/year)*	Amount and Frequency:

11. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.

12. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*

13.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? *(include age of onset)*	Age at Death & Cause
a.) Father			
b.) Mother			
c.) Sibling(s)			

14. Does the Proposed Insured **Yes** **No**

a) Use any assistive devices for walking such as a wheelchair, walker, or cane, or have difficulty ambulating? *(If "Yes", provide details.)* ☐ ☐

b) Drive? *(If "No", when and why did they stop?)* ☐ ☐

c) Have a history of falls in the past year? *(If "Yes", how many and provide details.)* ☐ ☐

d) Exercise? *(If "Yes", what type and how often?)* ☐ ☐

e) Need any assistance with the following activities: *(If "Yes", provide details.)*

Bathing ☐ ☐

Dressing ☐ ☐

House Cleaning ☐ ☐

Handling Finances ☐ ☐

Taking Medication ☐ ☐

Each of the Undersigned declares that:
I have read or have had read to me the completed Medical Supplement before signing below. All statements and answers in this Supplement are correctly recorded and are full, complete and true. I agree that this Medical Supplement constitutes a part of the application for insurance. I understand that any false statements or material misrepresentations may result in the loss of coverage under the policy.

Signed in _____, this _____ day of _____ _____
(state) (month) (year)

Signature of Proposed Insured
(Parent or Guardian if under 14 years of age)

Signature of Witness (Examiner/Licensed Representative/Agent)

Printed Name of Witness (Examiner/Licensed Representative/Agent)

MEDICAL EXAMINER'S REPORT

COMPLETE QUESTIONS 15-18 IF PROPOSED INSURED IS AGE [70] OR OLDER. IF NOT, PROCEED TO QUESTION 19 BELOW.

15. Point to three objects and ask the Proposed Insured to tell you what they are and indicate that you are going to ask them to recall these later. Record the 3 objects (i.e., pencil, chair, clock).

16. Ask the Proposed Insured today's date including the year, day of week, month and day of the month. Record his/her response.

17. Ask the Proposed Insured to recall the three objects identified earlier. Record his/her response.

18. In the space below this question, ask the Proposed Insured to draw a clock face, mark the hours and draw the hands to show the time 11:10.

19a.) Height *(In Shoes)*	b.) Did you measure?	c.) Weight *(Clothed)*	d.) Did you weigh?
_____ ft. / _____ in.	☐ Yes ☐ No	_____ lbs.	☐ Yes ☐ No

e.) Any change in weight in the past year? *(If "Yes", provide amount, if gain or loss.)* ☐ Yes ☐ No Amount _____ ☐ Gain ☐ Loss

20. **BLOOD PRESSURE** *(If above 140/90, report additional readings below):*				21. **PULSE**	At Rest	After Exercise	3 Min. Later
Systolic				Rate			
Diastolic				Irregularities per minute			

22. **HEART** Is there any: Enlargement ☐ Yes ☐ No Edema ☐ Yes ☐ No

Dyspnea ☐ Yes ☐ No Murmur(s) ☐ Yes ☐ No *(If more than one murmur describe each separately)*

☐ Constant	☐ Intermittent	☐ Transmitted	☐ Localized
☐ Systolic	☐ Presystolic	☐ Diastolic	
☐ Soft (Gr. 1-2)	☐ Mod. (Gr. 3-4)	☐ Loud (Gr. 5-6)	

Location:	**Transmission:**

MEDICAL EXAMINER'S REPORT - Continued

	Yes	No
23. Is there any abnormality of the following: (Circle Applicable items and give details. If more room is needed, provide details in Examiner's Confidential Opinion.)		
a) Eyes, ears, nose, mouth or pharynx? *(If vision or hearing is markedly impaired, indicate degree and correction.)*	☐	☐
b) Skin; lymph nodes; veins or peripheral arteries? (include scars)	☐	☐
c) Peripheral arteries or pulses?	☐	☐
d) Nervous system? (include reflexes, gait, paralysis)	☐	☐
e) Respiratory system?	☐	☐
f) Abdomen? (include scars)	☐	☐
g) Endocrine system? (include thyroid)	☐	☐
h) Musculoskeletal system? (include spine, joints, amputations, muscle strength)	☐	☐
i) Mental status?	☐	☐
24. Is there any use of adaptive devices? (cane, walker, wheelchair)	☐	☐
25. Is appearance unhealthy or older than stated age?	☐	☐
26. Are you aware of additional medical history; signs, symptoms or laboratory findings? *(A confidential report may be sent to the Medical Director.)*	☐	☐
a) Are you related to the Applicant?	☐	☐
b) Are you associated with the Applicant in any business or financial ventures?	☐	☐
27. Have you any reason to believe that the Applicant uses or has used alcoholic beverages or drugs to excess?	☐	☐
28. If you do any of the following, please indicate:	☐	☐

Sent to Lab: ☐ Blood Profile ☐ Urine Specimen

To Field Office: ☐ Chest X-Ray ☐ EKG ☐ Other _____

29. **EXAMINER'S CONFIDENTIAL OPINION:**

URINALYSIS: ALWAYS SEND A URINE SPECIMEN AND BLOOD SAMPLE (IF APPLICABLE) TO APPROPRIATE LAB.

Medical Examiner (Please Print)	**Examination Company P.O. Address**	**Examiner #**
Name of Agent (Please Print)	**Dated at** (City and State)	**Date**

I certify that I made this examination at _____ o'clock ☐ A.M. ☐ P.M. on the _____ day of _____, _____

_____
Signature of Examiner Designation

Lincoln Financial Group®

The Lincoln National Life Insurance Company
Service Office: [PO Box 21008, Greensboro, NC 27420-1008]
(hereinafter referred to as "the Company")

PREMIUM FINANCING SUPPLEMENT

Proposed Insured_____ Date of Birth *(mm/dd/yy)* _____

1. Please provide the name, address, contact person and telephone number for the lender (or other person or entity who is providing the funds to pay for this new life insurance policy):

_____

_____

2. a. Have you, the Proposed Insured, in the last two (2) years, received a life expectancy valuation or authorized a life expectancy valuation to be performed? ☐ Yes ☐ No
   b. Have you been asked to have a life expectancy valuation performed in the future? ☐ Yes ☐ No *(If "Yes," to either of the questions above, please provide a copy of this valuation and identify below who performed (or requested to have performed) the valuation.)*

_____

		Proposed Insured	Owner
3.	Do you expect to keep this new life insurance policy for at least five (5) years? *(If "No," please explain below why you do not expect to keep the policy as part of a permanent life insurance program.)*	☐Y ☐N	☐Y ☐N
4.	Is the life insurance policy the only collateral for the loan? *(If "No," please describe the additional collateral below.)*	☐Y ☐N	☐Y ☐N
5.	Were you given a copy of the loan term sheet that shows the loan interest rate, loan origination fees, maturity date, and prepayment penalties or fees? *(If "Yes," please attach a copy of the loan term sheet.)*	☐Y ☐N	☐Y ☐N
6.	Are any additional funds being loaned to the proposed insured or owner beyond the amount required to pay the premiums for the policy? *(If "Yes," please provide details below.)*	☐Y ☐N	☐Y ☐N
7.	If this policy is issued, have you (or a family member or other party of your choice) been offered any cash payment, free trip, or any other thing of value? *(If "Yes," please provide details below.)*	☐Y ☐N	☐Y ☐N
8.	Do the premium financing terms include an assignment of the death benefit to the lender that exceeds the amount funded to pay the premiums for the policy? *(If "Yes," please provide details below.)*	☐Y ☐N	☐Y ☐N
9.	Have you discussed, or been assured in writing, or otherwise, that regardless of the loan balance or cash surrender value of the policy, you can fully satisfy the outstanding loan by simply transferring all or a portion of your rights in the life insurance policy to the lender or another party without liability? *(If "Yes," please provide details below.)*	☐Y ☐N	☐Y ☐N

The Company is concerned that persons or entities are recommending the purchase of life insurance by representing that, within the next two to three years, the fair market value of the policy in the life settlement or other secondary market will equal or exceed the total premiums paid. I understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed, and that I may not be able to sell my policy for any amount in excess of the cash surrender value of the policy.

I have read or have had read to me the completed Premium Financing Supplement before signing below. All statements and answers in this Supplement are correctly recorded and are full, complete and true. I agree that this Premium Financing Supplement constitutes a part of my application for insurance. I understand that any false statements or material misrepresentations may result in the loss of coverage under the policy.

Signed in _____, this _____ day of _____ _____
(state) (month) (year)

_____ _____
Signature of Proposed Insured (Parent or Guardian if under 14 years of age) **Witness**

_____
Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

LFF06319 5/08

SERFF Tracking Number:	*JEPL-125673253*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	*39195*
Company Tracking Number:	*LFF06321 ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application Part I LFF06321 et al*		
Project Name/Number:	*/LFF06321 et al*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*JEPL-125673253*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	*39195*
Company Tracking Number:	*LFF06321 ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application Part I LFF06321 et al*		
Project Name/Number:	*/LFF06321 et al*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Readability Certification 06/03/2008

Comments:

Please see Readability Certification attached below.

Attachment:

AR_Readability.pdf

Arkansas

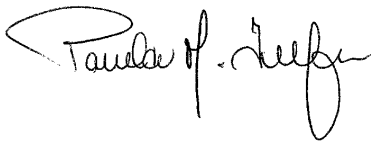
READABILITY CERTIFICATION

The Lincoln National Life Insurance Company

Re: ***LFF06321 – Application for Life Insurance (Part I)***
LFF06322 – Medical Supplement (Part II of Application)
LFF06319 – Premium Financing Supplement

We hereby certify that the attached Form(s) is (are) in compliance with the Rules and Regulation requirements regarding Life, Annuities, and Accident and Sickness Insurance Language Simplification Standards and has (have) achieved a Flesch Reading Ease score of:

Form Number:	***Flesch:***
LFF06321	***50.46***
LFF06322	***52.54***
LFF06319	***51.57***



Pamela M. Telfer, Assistant Vice President
Product Compliance

Date: May 29, 2008